BUSINESSPLANS
MYBENEFITSTATEMENTS | MYCAFETERIAPLAN | MYCOBRAPLAN

Flex Card Documentation Cover Sheet

If Faxing # of Pages:

This is for the submission of documentation to substantiate Flex Card transactions ONLY!

You will not be reimbursed for these expenses.

EMPLOYEE INFORMATION *(Please Print)*

Employer Name: _____

Name: _____

SSN (last 4 digits): _____

Email: _____

Phone: _____ ☐ Home ☐ Work

Does your documentation include all of the following?

Provider's Name and Address — Patient's Name

Service Description — Amount Charged

Date of Service

**** Credit card receipts are not acceptable ****

Date of charge	Claim #	Name of Provider	Amount

Mail To: myCafeteriaPlan, 432 East Pearl St., Miamisburg, OH 45342
Fax To: 937.865.6502

Access your account information 24 hours a day, seven days a week on our web site: www.myCafeteriaPlan.com